Obesity Strategy
London Borough of Redbridge
2016-2019
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Executive Summary

In Redbridge, one in ten (9.8%) 4-5 year olds and one in five (23.5%) 10-11 year olds are obese (NCMP 2015/16). This problem is not unique to children, with an estimated 66.7% adults living in the borough who overweight or obese. Contributing towards this picture is the fact that our residents consume less fruit and vegetables than the average Londoner (an indicator of healthy eating) and have historically had low levels of physical activity, although this has improved significantly in the last year. There is a proliferation of fast food outlets and travel by car is seen as the preferred method of transport for many residents. As obesity levels increase, it is crucial that we continue to take action to ensure more residents have a healthy weight.

We recognise that to make progress, a whole systems approach, focusing on prevention, is needed that begins from birth and continues throughout the life course. As well as providing residents with the knowledge, skills and opportunities to eat healthily and undertake physical activity, we need to create an environment that makes it easier for people to make healthy choices. To achieve this, we need to work together across the borough with a wide range of partners, learning from best practice and ensuring our resources are put to best use. To do this, we have established the Obesity Steering Group, a multi-agency group that has worked together to develop our local strategy and action plan.

This document provides more information on obesity, outlining why addressing this issue is important; explaining the contributory factors that lead to high levels of obesity; and providing more detail on the local picture.

1. Introduction

Obesity is one of the most important preventable challenges to health. Ranking as one of the most obese countries in Europe, 61% of the UK adult population is either obese or overweight, with the Foresight report estimating that over half of UK adults could be obese by 2050 (Foresight, 2007).

Investing in obesity prevention and management can bring a good return on investment (Public Health England, 2016). The estimated cost of obesity to the wider economy in England is £27 billion each year. £6.1bn is spent on NHS care, £13.3m on obesity medication, £352m on social care and £16m is linked to sick leave (see Figure 1).
Carrying excess weight is a serious threat to general health and wellbeing. Obesity doubles the risk of dying prematurely (Pischon, 2008). An obese Londoner is at greater risk of developing a number of diseases including type 2 diabetes, coronary heart disease, stroke and some cancers, as well as conditions such as depression and low self-esteem (see Figure 2). People who are moderately obese (BMI 30-35) have an average reduced life expectancy of three years, with people who are morbidly obese (BMI 40-50) having a reduced life expectancy of eight to ten years (National Obesity Observatory, 2010). In children and young people, obesity is associated with school absence in children. In adults, it is linked to increased sick leave and unemployment (Joseph Rowntree Foundation, 2008).

Obesity is associated with deprivation, with higher rates of obesity among people in lower socioeconomic groups, compared to those in higher socioeconomic groups. Obesity rates are highest for children in the most deprived areas and this is getting worse (H&SCIC, 2015). Among children, obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10% (National Obesity Observatory, 2016).

The National Child Measurement Programme shows substantial variation in levels of obesity among different ethnic groups. For adults, there is little national representation data but from what information is available, it shows that women from Black African groups appear to have the highest rates of obesity and men from Chinese and Bangladeshi groups have the lowest. Almost every minority ethnic group seems to have a higher prevalence of obesity than the average. The prevalence of health conditions linked to obesity, including cardiovascular disease and type 2 diabetes, also varies by ethnic group. The National Obesity Observatory highlight that it is particularly important for South Asian populations to be aware of the health risks associated with a high BMI and waist circumference (National Obesity Observatory, 2016).

People with disabilities are more likely to be obese and have lower rates of physical activity than the general population, although data is limited.

**What will this strategy mean for the residents of Redbridge?**

The implementation of this strategy will enable more local people to achieve and maintain a healthy weight. In particular, the outcomes that this strategy aims to achieve are:

- More children and adults who are a healthy weight.
- More families and individuals who are physically active.
- More residents eating at least five pieces of fruit and vegetables every day.

To achieve this, we plan to:

- Create an environment that facilitates healthy eating and physical activity, making the healthy choice, the easy choice.
- Provide residents with the knowledge, skills and opportunities to eat healthily and undertake physical activity.
- Support families and individuals who are overweight or obese to reduce their BMI and maintain a healthy weight.
2. Strategic Context

2.1 National Context

In 2011, the Department of Health outlined two targets associated with tackling obesity:

1. A sustained downward trend in the level of excess weight in children by 2020;
2. A downward trend in the level of excess weight (overweight and obese) averaged across all adults by 2020.

To achieve these targets, the national strategy, ‘Healthy lives, healthy people: a call to action on obesity in England’ (Department of Health, 2011), highlighted ‘the need to strike a balance between ‘treatment’ interventions that help individuals to reach a healthier weight and sustained preventive effort to help to make healthy weight increasingly the norm’. It also highlighted that it is vital that action on obesity reduces health inequalities; and described the need for a multi-agency response.

The strategy argued that action on food should include supporting and enabling consumers ‘to eat and drink fewer calories through product/menu reformulation, supporting the national sugar tax, reviewing portion sizes and food labelling, education and information on what a healthy diet consists of, and actions to shift the marketing mix towards lower calorie options’. It advised that work on physical activity should remove barriers to engagement and provide opportunities to increase the likelihood of physical activity. This includes encouraging active travel and making improvements to the working environment to encourage employees to be more physically active (Department of Health, 2011).

More recently, the government published ‘Childhood Obesity: A Plan for Action’ (Department of Health, 2016), which describes plans to significantly reduce England’s rate of childhood obesity within the next ten years. This includes plans to consult on the proposal for a levy on sugary soft drinks; work with industry to re-formulate food to reduce the level of sugar in food; a re-commitment to the Healthy Start Scheme; a review of the nutrient profile model and food labelling; and the promotion of new training materials for health care and the wider workforce to ‘make every contact count’. The ambition for every primary school child to get at least one hour of moderate to vigorous physical activity a day, with at least 30 minutes delivered by schools, is stated, with a range of actions outlined to help schools achieve this. This includes making available a new interactive online tool to help schools plan; doubling the primary P.E. and Sport Premium for primary schools; providing a co-ordinated offer of high quality sport and physical activity programmes; and continued investment in walking and cycling. Schools are also recognised as playing an important role in promoting healthy eating, with a further £10m promised for healthy breakfast clubs, and all schools are encouraged to commit to the School Food Standards. The plan explains that Public Health England will be developing advice for schools to help them understand how they can work with others to help children develop a healthier lifestyle; and a new voluntary healthy rating scheme will be introduced for primary schools, which will be taken into account during Ofsted inspections.

Actions to address healthy eating outside schools are also covered in the national action plan. Local authorities are encouraged to adopt the Government Buying Standards for Food and Catering Services, particularly in leisure centre vending machines, and the Children’s Food Trust will be developing revised menus for early years’ settings.

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1 The Healthy Start Scheme provides vouchers for fruit, vegetables and milk for families on low incomes.
2 The nutrient profile model is used to inform the restrictions on food and drink advertising.
2.2 Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF) sets out the vision for public health and works towards increasing healthy life expectancy and reducing differences in life expectancy and healthy life expectancy between communities. All local authorities are required to report on the PHOF. Tackling obesity falls within the ‘Health improvement’ strand of the PHOF. Preventing and managing obesity is also associated with ‘Healthcare public health and preventing premature mortality’ in the PHOF.

2.3 Regional Context

A higher proportion of London’s children are overweight or obese compared to children in other parts of England (Public Health England, 2016). To address the issue in London, Redbridge Public Health has been involved in the Regional Growth Borough initiative that is supporting local authorities and public health partners from London boroughs to take a whole systems approach to tackling obesity. Redbridge has also been involved in the Healthier Child, Healthier Place programme which is part of the Olympic legacy work. Redbridge was invited to participate in various meetings with different topics relating to healthy weight and are taking forward the learning from this work. In addition, the London Mayor’s office launched the Healthy Schools London programme in April 2013 to support schools to cultivate environments that support the health and wellbeing of children and promote healthy weight, and a number of Redbridge schools have now achieved Healthy Schools status.

2.4 Local Context

In 2013, Public Health became the Council’s statutory responsibility which means that the relationship between Public Health and other Council departments has been strengthened. As an example, the Council is refreshing its Local Plan for 2015-2030 which sets out where, when and how growth will take place across the borough. The plan includes a section specifically on health and wellbeing, and makes a commitment to resist the proliferation of hot food takeaways in the borough, promote Redbridge’s open spaces and parks, and support active travel.

The Council has a number of relevant strategies that highlight the obesity agenda, including the Health and Wellbeing Strategy (2012-15), the Leisure and Culture Strategy (2015), Redbridge Cycle Strategy (2011), Redbridge Walking Strategy (2012), and Redbridge Sustainable Modes of Travel Strategy (April 2016).

Redbridge has a multi-agency Obesity Steering Group made up of senior stakeholders. The group has contributed to developing an obesity strategy and action plan, and works in partnership to deliver the action plan.
3. Defining and Measuring Obesity

Among adults, obesity is commonly measured by calculating Body Mass Index (BMI) as follows:

\[
BMI = \frac{\text{Weight (Kg)}}{\text{Height}^2 (m^2)}
\]

The table below shows how people’s weight is categorised depending on their BMI measurement:

<table>
<thead>
<tr>
<th>Category</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.5</td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>18.5 – 24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0 - 29.9</td>
</tr>
<tr>
<td>Obesity I</td>
<td>30.0 – 34.9</td>
</tr>
<tr>
<td>Obesity II</td>
<td>35.0 - 39.9</td>
</tr>
<tr>
<td>Obesity III</td>
<td>&gt;40</td>
</tr>
</tbody>
</table>


Other alternative measures used to assess the level of fat among adults include waist circumference, waist hip ratio, neck measurement and skin fold thickness. However, due to the practicalities of these methods, BMI is generally used, especially at a population level. For children, the national standardised growth charts allow children’s weight status to be compared with that of children their age and gender. In England, the British 1990 growth chart is used to assess the weight status of children (Department of Health, 2009).

The World Health Organisation (WHO, 2012) highlighted research pertaining to BMI cut-off points in Asian populations which suggest that the risk profile above varies in different Asian populations. There is a suggestion that the overweight risk varies from 22Kg/m² to 25 kg/m² amongst different Asian populations (WHO 2012). However, whilst it is important to highlight this, given the culturally diverse nature of the borough, the boundaries have not been changed following this research and therefore we currently continue to use the general BMI classification for all ethnic groups.
3.1 Obesity: Contributory Factors

The Foresight report employed a systems mapping approach to identify the determinants of obesity. Among the seven determinants of obesity, some can be controlled and managed, whilst there are others where we have no control or influence over. Table 2 demonstrates which of these seven factors are linked to individuals and which are influenced by the environment (Foresight report, 2007).

Table 2: Determinants of obesity

<table>
<thead>
<tr>
<th>Individual</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biology: recognition of the influence of genetics and ill health on weight.</td>
<td>Activity environment: the influence of the environment on an individual's activity behaviour. For example, a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers.</td>
</tr>
<tr>
<td>Physical activity: the type, frequency and intensity of activities undertaken by individuals.</td>
<td>Societal influences: the impact of society on weight; this includes influences of the media, education, peer pressure, culture etc.</td>
</tr>
<tr>
<td>Individual psychology: a person’s individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences has an impact on weight.</td>
<td>Food environment: the influence of the food environment on an individual’s food choices. For example, a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home.</td>
</tr>
<tr>
<td>Food consumption: the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual’s diet.</td>
<td>Food environment: Portion sizes and the way that food is prepared in food outlets e.g. deep fried.</td>
</tr>
</tbody>
</table>


4. Healthy Eating and Physical Activity

As outlined above, supporting people to eat healthily and undertake physical activity is a critical part of addressing obesity levels in the borough. The following outlines why this is important.

4.1 Healthy Eating

What we eat has a profound effect on our health. Consuming too many calories than the body requires can lead to weight gain and, overtime, can lead to obesity. This is more likely if a person’s diet is high in saturated fat and sugar. A healthy diet is one that is rich in vegetables, pulses, fruits, nuts and whole grains. Modest portions of lean meat, poultry, white and oily fish, soya foods, low fat dairy products and vegetable based spreads and oils also play an important role in a healthy diet, as they are low in saturated fat and rich in a range of other essential nutrients. Public Health England has produced the ‘The Eatwell Guide’ which is a tool used to define government recommendations on eating healthily and achieving a balanced diet (see Figure 3) (Public Health England, 2015). The visual representation makes healthy eating choices easier to understand, in particular the types and proportions of foods needed for a healthy and well balanced diet.
**Figure 3. The Eatwell Guide**

![Eatwell Guide](image-url)


### 4.2 Physical Activity

A lack of physical activity has contributed towards the increasing levels of obesity UK. Physical inactivity is classed as less than 30 minutes of physical activity per week, with failure to reach the above recommendations associated with negative health outcomes (British Heart Foundation, 2015).

The Department of Health reports that physical inactivity is the 4th largest preventable cause of death after blood pressure, smoking and obesity. They estimate that being physically active can lower the risk of heart disease and stroke by between 20% and 35%, and lower the risk of certain cancers, such as bowel cancer by 30-50% and breast cancer by 20%. It is estimated that physical inactivity is responsible for 17% of premature deaths in the UK each year and shortens life expectancy by 3 to 5 years. There is also some research to suggest that physical activity reduces symptoms of depression and anxiety and improves self-esteem (Department of Health, 2011). Even relatively small increases in physical activity are associated with some protection against chronic disease and an improved quality of life.

The Chief Medical Officer (CMO, 2011) has devised a set of recommendations for adults and children outlining the minimum activity required to maintain a healthy lifestyle. The recommendations can be seen in Figure 4 below:
4.3 Active Travel

Active commuting has been linked directly with a decreased risk of overweight and obesity. Walking or using a bicycle for transport has been observed to have a positive effect on physical activity levels in adults and children. Even active travel as part of a journey combined with public transport has been demonstrated to have a beneficial effect on physical activity levels. There is a growing body of research which suggests that active travel may be the most effective means of increasing population-level physical activity (Public Health England, 2013).

5. Obesity: The Picture for Redbridge

The London Borough of Redbridge, located in the outer north-east region of London, has an estimated population size of 296,4793 people (Office for National Statistics, 2015). Redbridge shares borders with Waltham Forest, Havering, Newham, Barking and Dagenham, and Essex. In contrast to its fairly affluent and ‘leafy’ suburban characteristics, seven out of the 21 wards in Redbridge are in the top 20% of the most deprived wards in England and Wales, with the south of the borough ranking particularly high on the Index of Multiple Deprivation (IMD). However, it is
important to note that some of the most affluent wards, such as Wanstead and Monkhams, do have pockets of deprivation, and obesity is a growing issue even in very affluent parts of the borough.

Tackling obesity in Redbridge is a complex issue, in part due to the fact it is a highly culturally diverse borough: Redbridge ranks 4th most ethnically diverse local authority in England, with ethnic minority groups making up 66% of Redbridge residents (Runnymede Trust, 2014).

5.1 Obesity in adults

It is estimated that 66.7% of adults (aged 16 years and over) in Redbridge are either overweight or obese (Active people survey, 2013-2015). Figure 5 shows the prevalence of obesity and overweight among adults in Redbridge and neighbouring boroughs, and their comparison to the London and England average. It indicates that Redbridge’s overweight and obesity levels are higher than both the London and England average.
Figure 5: Percentage of adults aged 16 years and over classified as overweight or obese

Source: Active People Survey 2013-15.

5.2 Obesity in children

Obesity prevalence in Reception and Year 6 in Redbridge, London and England, 2006/7-2015/16

Figure 6 shows that the prevalence of obesity in reception (9.8%) has slightly fallen compared to last year (10.8%). This means that Redbridge’s reception obesity rates are the lowest they have been since the NCMP began. Rates are lower than the London average of 10.3% but still higher than the England average of 9.3%.

Figure 7 shows that the prevalence of obesity in year 6 in Redbridge has slightly increased since last year from 23.2% to 23.5% which is similar to London (23.2%) and above England (19.8%).
Figure 6. Obesity prevalence in reception in Redbridge, London and England, 2006/7-2015/16

Figure 7. Obesity prevalence in year 6 in Redbridge, London and England, 2006/7-2015/16

Source: National Child Measurement Programme, 2015/16
5.2.1 Gender

Figure 8 shows that the prevalence of obesity is higher in boys compared to girls in both reception (boys 10.2% and girls 9.2%) and year 6 (boys 26.5% and girls 19.8%).

The proportion of girls in reception with excess weight (18.1%) in Redbridge is slightly lower than the proportion of boys (19.2%) and once again a similar pattern can be observed when looking at excess weight in year 6, with boys having a higher prevalence (41.9%) compared to girls (36.2%).

Figure 8: Excess weight and obesity prevalence in reception and year 6 by gender, 2015/16

Source: National Child Measurement Programme, 2015/16
5.2.2 Ethnicity

Figures 9 and 10 show the prevalence of obesity in reception and year 6 by ethnic group over time. They show that Black children have the highest rates of obesity among ethnic groups in both school years.

Figure 9 shows the proportion of Black children in reception who are obese has consistently remained above the average for Redbridge. However, this rate has fallen from 17.7% in 2014/15 to 13.7% in 2015/16, which is the lowest recorded figure for Black children since the NCMP began. With the exception of those from a mixed background, obesity rates fell in all ethnic groups.

Figure 10 shows the proportion of Black (26.9%) and Asian (24.2%) children in Year 6 who are obese is higher than the Redbridge average (23.3%). All ethnicities have seen an increase in their obesity levels this year.

Figure 9. Obesity prevalence in reception by ethnicity, 2010/11 - 2015/16

Source: National Child Measurement Programme, 2015/16
Figure 10. Obesity prevalence in year 6 by ethnicity, 2010/11 - 2015/16

Source: National Child Measurement Programme, 2015/16
5.2.3 Geography

Figures 11 and 12 are geographical maps showing the obesity rates in reception and year 6 by Redbridge wards. In reception, Snaresbrook has a significantly lower rate of obesity than the Redbridge average. The wards in darker red show where the higher rates of obesity are in the borough although these are not statistically different.

In year 6, both Monkham and Church End have significantly lower rates of obesity than the Redbridge average. Again, the wards in darker red show where the higher rates of obesity are in the borough although these are not statistically different.

Figure 11. Obesity levels in reception by ward, 2015/16
Figure 12: Obesity levels in Year 6 by ward, 2015/16

Significance to Redbridge
- Red: Higher than Redbridge but not significantly different
- Pink: Lower than Redbridge but not significantly different
- Light pink: Significantly lower than Redbridge

Source: National Child Measurement Programme, 2015/16
5.3 Physical Activity – Current picture and trends

Physical inactivity in Redbridge is estimated to cost the borough £19,354,909 per year (UK Active, 2014).

Figure 13 shows that in 2015, 57.5% of the Redbridge population achieved the recommended 150 minutes of physical activity per week. This is a significant increase from last year and means that Redbridge is now similar to the England average (57%) and London average (57.8%).

Redbridge residents do less active travel than the average Londoner: in 2014/15, 85.1% of residents did any walking or cycling at least once per month (for any purpose), compared to an average of 89.7% across London (Department for Transport, 2016).

**Figure 13. Percentage of physically active adults, 2012-15**

![Graph showing percentage of physically active adults](image)

Source: PHOF

5.4 Healthy Eating

Redbridge ranks low in terms of fruit and vegetable consumption, compared to other London boroughs. In Redbridge, the proportion of the population meeting the recommended ‘5-a-day’ is 47.1%, which is lower than the London (49.4%) and England (52.3%) averages. The average number of fruit consumed daily is 2.44 in Redbridge, compared to 2.47 in London and 2.51 in England, and the average number of vegetables consume daily in Redbridge is 2.12, compared to 2.18 in London and 2.27 in England (Public Health Outcomes Framework, 2015). One of the contributory factors for the low consumption of fruit and vegetables may be due to the high concentration of fast food outlets in the borough that provide poor quality food at low prices. Among some population groups, there may also be a lack of knowledge around how to prepare healthy meals for their families.
6. **Tackling Obesity, the Redbridge Strategy**

To tackle obesity, we need to make it easier for residents to make healthy choices, in particular supporting them to have a healthy diet, undertake physical activity and maintain a healthy weight. We recognise that tackling obesity is a highly complex and challenging issue that requires a long-term, multi-faceted approach to bring about positive change, and we need to be realistic about what can be achieved over short timeframes. We believe that through tackling the wider determinants of health, as well as offering individual support, we will begin to see a positive impact on our current obesity levels. As outlined above, to reduce obesity levels in the borough, we plan to work in partnership to:

- Create an environment that facilitates healthy eating and physical activity, making the healthy choice, the easy choice.
- Provide residents with the knowledge, skills and opportunities to eat healthily and undertake physical activity.
- Support families and individuals who are overweight or obese to reduce their BMI and maintain a healthy weight.

This will be achieved through a programme of work to ensure that we have healthy places across Redbridge; healthy spaces, such as children centres and other public facilities; and healthy services that offer individuals a range of physical activity and healthy eating opportunities. This work is detailed in Redbridge’s Obesity Action Plan and will involve a wide range of partners.

**Figure 14: Partnership: the key to success**

7. Governance

The development of borough’s Obesity Strategy and Action Plan has been overseen by Redbridge’s Obesity Steering Group, a multi-agency and multi-disciplinary group comprising of members from the local authority, NHS and voluntary sector, and accountable to the Health and Wellbeing Board.

The purpose of the group is:

- To develop and agree Redbridge’s obesity strategy.
- To work in partnership to implement the strategy and action plan.
- To monitor and evaluate implementation of the strategy and action plan.
- To identify new needs as they arise and identify ways to meet these.
- To ensure there is an effective pathway for the prevention, management and treatment of underweight, overweight and obesity.
8. References


Department of Health (2011). Start Active Stay Active: a report on physical activity for health from the four home countries.


Department of Transport (2016). Walking and cycling statistics.


UK Active, Turning the tide of Physical Inactivity, 2014.
